Preferred EAP
When you need to talk... there's someone to listen.

Client Information

Name: _____ Date: _____ Chart #:_____

In order for you to have more useful time with your counselor, we request you complete this form. Please answer all of the questions as accurately as possible. All responses are strictly confidential. **Thank you**.

HEALTH INFORMATION

Name of personal doctor: _____

Current medical problems: _____

_____

Are current medical problems being treated? ____ Yes ___ No

Do you take any medication on a regular basis? ____ Yes ___ No

If yes, please list: _____

_____

Have you ever seen a counselor, psychologist or psychiatrist before today? ____ Yes ___ No

If yes, who and when: _____

Have you ever been hospitalized for an emotional or drug/alcohol problem? ____ Yes ___ No

If yes, where and when: _____

Do you have health insurance? ____ Yes ___ No

Primary Insurance Company: _____

Insurance Group Number: _____

Please check below any symptoms experienced during the last six (6) months.

___ insomnia
___ digestive problems
___ headaches
___ unusual sleepiness
___ frequent colds
___ back/neck aches
___ appetite changes
___ sinus problems

Have you ever had a problem related to ___ Eating ___ Gambling ___ Shopping
___ Spending ___ Sexual activity ___ The Internet

OVER →

Name: _____ Chart #:_____

BEHAVIORAL HISTORY

Yes	No	
___	___	Do you drink coffee, tea or other caffeinated products?
___	___	Do you smoke or otherwise use tobacco products?
		• If so, do you want information on the Tobacco Treatment Program? __ Yes ___ No
___	___	Have you ever used alcohol or drugs?
___	___	Do you sometimes drink more than you had planned?
___	___	Have family or friends ever expressed concern about your use of alcohol or drugs?
___	___	Have you ever been arrested for alcohol or drug related charges?
___	___	Have you ever had medical or counseling treatment for drinking or drug use?
___	___	Have you ever had episodes when you were drinking when you were unable to remember?
___	___	Have family or friends ever expressed concern over your use of drugs?
___	___	Have you ever been arrested for any offense involving drugs?
___	___	Have you ever overdosed on drugs accidentally or purposely?
___	___	Have any members of your family had problems with drugs or alcohol?

RISK FACTORS

Yes	No	
___	___	Do you know anyone who has ever attempted suicide?
___	___	Have you, in the last year, ever considered suicide?
___	___	Have you ever attempted suicide?
___	___	Have you ever been exposed to trauma situations (for example, victim of domestic violence or physical or sexual abuse, exposed to combat or involved in a serious accident)?

If yes, please explain: _____

JOB/SCHOOL PERFORMANCE HISTORY

My job/school performance has been affected by my personal problem. _____ Yes _____ No

- If you answered "yes", above, in what way has your performance affected? Please check all that apply.

  _____ Absenteeism / lost time
  _____ Frequent visits to the Medical Department
  _____ Tardiness / early quit
  _____ Accident / near miss
  _____ Mistakes / complaints
  _____ Under-the-influence
  _____ On-the-job conflict or relationship problem
  _____ Inappropriate behavior
  _____ Distraction / pre-occupation
  _____ Other:
  _____

- If you answered "yes" above, what is your best estimate of how much "productive work time" may have been "lost" during the month before you came to Preferred EAP?

  _____ Less than 8 hours total or less than 2 hours/week
  _____ Between 8 and 16 hours or between 2 and 4 hours/week
  _____ Between 16 and 24 hours or between 4 and 6 hours/week
  _____ Between 24 and 32 hours or between 6 and 8 hours/week
  _____ More than 32 hours total or more than 8 hours/week